DOCUMENT RESUME

ED 187 079 EC 124 344

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TITLE Development and Implementation of an Effective Early Childhood Handicapped Program.
INSTITUTION Kenosha Unified School District 1, Wis. Dept. of Special Education.
PUB DATE Apr 80
NOTE 23p.; Paper presented at the Annual International Convention of The Council for Exceptional Children (58th, Philadelphia, PA, April, 1980, Session F-70).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Cognitive Development; *Disabilities; *Early Childhood Education; *Educational Diagnosis; Emotional Development; Hearing Impairments; *Mainstreaming; Motor Development; Occupational Therapy; Physical Disabilities; Program Descriptions; Screening Tests; Self Help Programs; Skill Development; *Social Development; Speech Handicaps

ABSTRACT

The paper describes the Early Childhood Handicapped Program of Kenosha (WI). The program focuses on receptive and expressive language, fine and gross motor skills, self-help skills, cognitive skills, perceptual skills, and social/emotional skills development. For admission into the program, children must exhibit significant delays in two or more areas. Five classrooms serve the needs of approximately fifty 3 to 6 year old exceptional children. Two of the classes are self-contained, two have a self-contained/integrated structure, and the fifth classroom provides maximum integration with normal children. Specific programs are ongoing in the areas of physical handicaps, speech impairments, and hearing impairments; and physical and occupational therapy is offered. Screening procedures include at home interviews, hearing tests, and psychological/educational evaluations by a team. Supportive components, such as parent involvement and behavior management programs, are important aspects of the overall program. Twenty-four tests and/or assessment instruments are briefly described. (PHR)

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DEVELOPMENT AND IMPLEMENTATION OF AN EFFECTIVE EARLY CHILDHOOD HANDICAPPED PROGRAM

April 1980

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DEVELOPMENT AND IMPLEMENTATION OF AN EFFECTIVE EARLY CHILDHOOD HANDICAPPED PROGRAM

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The following paper is designed to explain the Early Childhood Handicapped Program in the Kenosha Unified School District No. 1, Department of Special Education. This program is in direct compliance with Federal and State guidelines governing Exceptional Education of preschool Children.

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Kenosha Unified School District No. 1
DEPARTMENT OF SPECIAL EDUCATION

Early Childhood Handicapped Program

1979-80 School Year

I. GENERAL PHILOSOPHY

Early Childhood Education is crucial to the development of handicapped children. Environments foster the rate of an individual's intellectual and emotional development. Since experience is important in growth and development, children should encounter environments during the early years of life that will help them to achieve a faster rate of intellectual development. Most behavior characteristics change more rapidly during infancy and early childhood. Experience has a greater impact during the period in which a particular behavior characteristic is undergoing relatively rapid change. Therefore, manipulation of experience has the greatest effect during the first years of life, and this can be achieved through an Early Age Educational Program.

Bloom, B., Stability and Change in Human Characteristics (New York: John Wiley, 1964)

II. OVERVIEW OF KENOSHA UNIFIED SCHOOL DISTRICT NO. 1 EARLY CHILDHOOD HANDICAPPED PROGRAM

The Early Childhood Handicapped Program of the Kenosha Unified School District No. 1 is patterned after a formal structured model. The present program has been in effect for three years. It focuses on the areas of Receptive and Expressive Language, Gross Motor, Fine Motor, Self-Help Skills, Cognition, Perceptual Skills and Social-Emotional Development. Children must exhibit significant delays in two or more areas in order to be placed into the program. An exception to this criteria is a child experiencing significant Language deficits without accompanying developmental delays. Significant delays are considered to be within a 20 to 30 percent range and beyond.

Five classrooms service the exceptional educational needs of approximately 50 children, ages 3 years to 5 years, 11 months. Four classrooms are housed in the exceptional education wing of Jane Vernon Elementary School. This provides close access to both Physical and Occupational Therapy Services which are also housed at Jane Vernon School. Two of these classes are self-contained in nature, and generally provide services to younger children. The other two classrooms at Jane Vernon School provide programming for older children and are self contained/integrated in structure. The children in these classrooms are integrated into regular education settings to varying degrees if appropriate. The fifth E.C.H. classroom is housed within the Curtis Strange Elementary School. In this setting the children are provided with maximum integration which provides a least restrictive environment.

The program consists of five E.C.H. Teachers, three Aides, one Speech Clinician, one Diagnostic Speech Clinician and a Psychologist. Social Work Services are available as well as Physical and Occupational Therapy (based on medical prescriptions).

The goal of the program is to increase the adaptive functioning of the child by structuring the rate and direction of learning. As the child grows, learns and develops skills, progress can be significantly influenced by adding certain conditions within both the educational and home environments. More complex behavior patterns are introduced, which aids the child in coping with his environment and in progressing through the normal developmental stages.

III. HISTORY OF PRESCHOOL EXCEPTIONAL EDUCATIONAL PROGRAMMING IN KENOSHA

The early years of preschool programming in Kenosha took the form of a self-contained school for the retarded. In later years this was expanded to include an early age classroom for preschool children with speech and language deficits. It was later determined that many of the children with speech and language deficits had other accompanying developmental delays. The Early Age Program evolved from this group of children who were found to have developmental delays in other areas besides, and including speech and language.

IV. CURRENT EXCEPTIONAL EDUCATIONAL PROGRAMMING FOR PRESCHOOL CHILDREN

a) Early Childhood Handicapped Program

The Early Childhood Handicapped Program in the Kenosha Unified School District is a non-categorical program. As mentioned previously, approximately 50 children with significant developmental delays are currently being served. A detailed description of classroom models will follow later in this paper.

b) Physically Handicapped Program

Although preschool handicapped children are not labeled following an M-Team evaluation, some disabilities are categorical by nature. Utilizing a team approach, a child with a physical disability and/or orthopedic problem may receive dual programming. Teachers of both Early Childhood and the Physically Handicapped may support this child to assure optimum growth and development.

c) Hearing Impaired Program

A hearing impairment is another such disability that is categorical by nature. A preschool child determined to have a educationally handicapping hearing loss may receive the services of both an E.C.H. Teacher as well as a teacher of the Hearing Impaired. Dual programming in such a case can provide the necessary input from a H.I. teacher, (e.x., manual communication, hearing aid orientation, etc.), and also allow the child an opportunity to interact with normal hearing peers.

d) Speech Impact Program

The Speech Impact Class is available to the 3-6 year old population who have a diagnosed speech articulation handicapping condition. The children are served in a small class or group situation by two speech clinicians. The class meets daily for 1 1/2 hours. There is the opportunity for individual therapy for special needs as in the case of children with cleft palates and/or a physical limitations as well as group intervention for functional articulation disorders.

e) Physical and Occupational Therapies

Physical and Occupational Therapy is available to any preschool child with an Exceptional Education Need having a medical prescription for such support. Children are seen individually for treatment and therapists consult with EEN teachers for any classroom modifications that are necessary.

V. REFERRAL PROCEDURES

a) Past Procedures

In the past, all referrals for diagnostic services for preschool children resulted in a complete evaluation. Referrals primarily generated from pediatricians, parents, nursery school teachers, day care centers and other agencies supplying intervention to the 0-3 year old population.

b) Present Procedures

Currently, referrals for diagnostic services continue to generate from the above listed sources. The difference is in their follow-up. Referrals on children with previously diagnosed developmental delays who may be serviced in community 0-3 year old programs will upon referral be scheduled for a complete Multidisciplinary Team evaluation. (See M-team composition on page 7.) Other referrals take the form of Screening referrals. These cases are followed up upon by the school psychologist and diagnostic speech/language clinician. It is their responsibility to determine if, indeed, a disability is present and the need for Multidisciplinary Team evaluation is in order.

The purpose for the change in procedures was based on the number of previous Multidisciplinary Team evaluations that resulted in no exceptional educational needs present. Many of the referral sources indicated questions or concerns regarding a child's development. Once these questions were answered or suggestions for development were given, the children matured and delays that were previously noted were no longer present or minimally affecting the child's functioning.

VI. REFERRAL FOLLOW-UP

a) Screening Level

1) Screening Team

All referrals via the phone are taken by the Child Find Specialist. Vital information, such as the child's name, address, phone number, present suspected problems and involvement with other agencies are compiled on a screening form.

The Screening forms are forwarded to the School Psychologist and Diagnostic Speech Clinician.

2) Screening Procedures (Past/Present)

In the past, these screenings were performed once or twice a month. The procedure was to have the children developmentally screened at one hour intervals at an elementary school. This procedure was found to be ineffective. The younger children had difficulty separating from their parents, in order to complete the screening. It also was apparent that these screenings resulted in inaccurate results.

The current procedure is for the School Psychologist and Diagnostic Speech Clinician to schedule a time to meet in the home of the child referred. A social/medical history is completed with the parent as informant. A discussion centers around the child's possible handicapping condition. A parental Questionnaire is completed to assess the child's development in areas of receptive/expressive language, self-help, social, gross and fine motor skills. The Denver Screening Test is administered to the child as is a receptive/expressive language and speech articulation screening. An audiometric hearing screening is performed. These serve as a contrasting assessment to what the parent has reported. The approximate length for each screening is 1 to 1-1/2 hours.

The parents are informed that the results obtained will be investigated and a summary in the form of a letter will be mailed to them. On screenings that result in no suspected exceptional educational needs, the parents are generally sent recommendations or ideas for further enhancing their child's development. On screenings that result in suspected exceptional educational needs, the parents are informed that a referral is being made to the Department of Special Education to further evaluate their child for possible exceptional educational needs in the area of Early Childhood Development.

b) Multidisciplinary Team Level

1) Referrals

Referrals for an M-Team evaluation can originate from any number of sources, included in these are: Pediatricians, Clinics, Nursery Schools, Community Agencies, Parents, Public School Personel and the Early Age Screening Team. Referrals are recorded by the M-Team Systems Manager and in turn given to the Early Childhood Psychologist (Case Manager) who arranges the evaluation and obtains the necessary parent permission.

2) M-Team Composition

All Early Childhood M-Teams consist of a School Psychologist, Speech Clinician and Early Childhood Handicapped teacher. Additional members are added at the discretion of the Case Manager and M-Team members. Additional members can include: Teachers of the Physically Handicapped, Hearing Impaired, Visually Handicapped, Learning Disabilities, Mental Retardation, Emotionally Disturbed, School Social Workers and both Physical and Occupational Therapists. Teachers for the before mentioned special areas are generally added on re-evaluation of children leaving the program due to age requirements. Such teachers are needed in order to determine continuing exceptional education needs.

3) Testing Procedures

Early Childhood evaluation procedures have changed markedly over the last three years to the point where current procedures are smooth and systematic and provide a good deal of information about a child. Initially, a child was seen individually by each M-team member. The psychologist would meet with the parents to secure permission and obtain a social/medical history, followed by an individual evaluation session with the child. Similarly, the speech clinician and the early childhood teacher would work individually with the child. This procedure resulted in a number of problems the least of which necessitated the parents transporting the child to school a minimum of two times. In addition, there was much duplication of testing, which often lead to inconsistent results. The child was not seen within a group setting to observe interactions thus, much information in the social area was based on parent report.

In order to facilitate the diagnostic process and to provide information from a number of settings, the following changes were implemented: An initial intake conference with the parents is scheduled where permission is obtained and a social/medical history is completed. At this time all parents are given a copy of the Minnesota Child Development Inventory, to take home and complete. This questionnaire provides information about the child's functioning in all

developmental areas. The questions are answered from the parents perspective and provide and index all of the developmental functioning with the home setting. Following this intake, a single evaluation session is completed with both the speech clinician and psychologist working with the child. This team approach is practical since much of the developmental assessment is duplicated with receptive and expressive language testing. Often the child has been found to relate better to developmental activities and spontaneous language is able to be observed and recorded. Articulation testing and hearing screening is performed by the speech clinician.

Upon the completion of this initial session, a second appointment is arranged with both parents and the E.C.H. teacher assigned to the M-Team. This appointment is generally much lengthier as the child will attend a half day session within the E.C.H. Classroom. Teachers generally are able to complete individual assessment, however, an emphasis is placed on how the child interacts within the school environment. Activities during this session allow for observation of motor functioning, language, social skills and self care skills. All children attend the lunch period which provides observations of feeding skills. If additional members are involved such as O.T., P.T., etc. this half day evaluation session allows ample time to complete these diagnostic components.

When an M-Team meeting is scheduled with the parents the information obtained on the child generally provides a good indication of functioning levels from which recommendations are made. Information has been gathered from an individual testing session, group setting (classroom) as well as the home.

VII. SUMMER DIAGNOSTICS

Following kindergarten screening, the children suspected of having the greatest need for exceptional educational services are selected for summer early age diagnostic evaluation.

In the past, those children in need of evaluations after kindergarten screening were scheduled to attend a four, one-half day, group and individual diagnostic class held at an elementary school. The children in need of the Early Age Program were then able to begin school in September within their special education classroom. The diagnostic class was run by the School Psychologist, Speech Clinician and Early Childhood Teacher who were in essence the Multidisciplinary Team.

This manner of diagnostics was effective but very time consuming. It was determined that the quality of the Multidisciplinary Team's evaluation would not be lessened if the diagnostic program was shortened.

The summer diagnostic program at the current time still involves those children with the greatest potential need for special education. The Psychologist, Speech Clinician and Early Age Teacher schedule individually their diagnostic session with one child, held at a time. The Multidisciplinary Team then meets to determine the need for exceptional education. This has proven to be both an efficient and effective manner of diagnostics. The children who have Exceptional Education Needs still start school within their special education classroom if the need is proven.

The main purpose for this summer diagnostic program is to allow children with exceptional education needs to begin their school experience in a successful atmosphere. Before this summer program was initiated, children frequently were unsuccessful in their kindergarten classes before a referral was made for exceptional educational testing. The summer diagnostic program was initiated to eliminate this situation for the child.

VIII. CLASSROOM MODELS

The classroom models of the Kenosha Early Childhood Handicapped Program have undergone a significant change since the program conception. In its first year, classrooms typified a disability model even though children were not labeled and the program itself was categorical. Children with speech and language delays were placed in a class which emphasized these areas. Children experiencing social/emotional problems were placed together. Children with cognitive delays were grouped together as were those with motor and perceptual delays. This grouping took place without respect to chronological ages, thus the age range within anyone room was three to six.

The difficulties encountered with this model are obvious. Instruction was difficult due to the wide range of functioning levels. Since those experiencing similiar problems were together, there were little opportunities for appropriate peer modeling. The children although not labeled in the strictest sense, were in fact grouped as though labeled.

In the second year, classroom models were changed to consider developmental and chronological ages in terms of placement rather than areas of delay. This approach is currently in use within the Early Childhood Handicapped Program. The following is a brief description of the five E.C.H. classrooms in the Kenosha Unified School District.

Classroom #1

This classroom services children within the developmental range of twelve months to thirty months. This classroom is self-contained in nature and emphasizes early developmental skills. Much of the time is spent acclamating the children to the school environment and schedules.

Classroom #2

This classroom services children within the developmental range of eighteen months to thirty months. The chronological ages of these children range from four to six years. Children are again self-contained and the curriculum emphasizes beginning independent self care skills and other appropriate developmental skills.

Classroom #3

The developmental range of these children is between three years and a mid-five year level. Their chronological ages are five and six years. An emphasis is placed on pre-readiness and independent developmental skills. Familiarization to school rules and practices is also stressed. Limited integration is accomplished for socialization at the Early Childhood Teacher's discretion. These children are likely to have continuing Exceptional Educational Needs upon leaving the program.

Classroom #4

Although these children are younger chronologically than those children in Classroom #3, developmentally the majority are at a higher level. Chronological ages range from four to six, however, developmental ranges are from three years to a mid-five year level. Independent developmental skills as well as pre-readiness activities are emphasized. A regular education curriculum is introduced to these children as a number are integrated for socialization purposes. A transition is made in this classroom from concrete level functioning to some selected representational (worksheets) activities.

Classroom #5

Children in this classroom are chronologically five and six years of age. Developmentally, they are functioning at an upper four to beginning five year range. This classroom is housed in a regular education elementary school which facilitates integration into two kindergarten classes. An emphasis is placed on readiness activities with some continued support in higher level developmental skills. The curriculum is much the same as a regular education kindergarten class. Children are then able to be integrated with little or no change in instructional materials. Integration is done from a minimum socialization period, to a half day kindergarten period. Many of these children will eventually be dismissed from special education and no longer exhibit EEN's.

Dismissal and Transitional Program

All children are re-evaluated if they reach six years of age prior to September 1st. Children who are determined to have continuing exceptional education needs are programmed for accordingly. Those children determined to have no exceptional education needs enter a transition program. These children enter regular education classrooms and E.C.H. teachers follow-up with their regular education teachers on a scheduled basis. This follow-up which can be performed for up to one academic year takes the form of consultation with no direct hands on support.

Many of the children continue to have speech or language exceptional education needs upon dismissal from the Early Age Program. These children continue to receive itinerant speech/language services within the regular education classrooms.

IX. SUPPORTIVE COMPONENTS OF THE E.C.H. PROGRAM

Parent Involvement

On eof the original objectives of the Kenosha Early Childhood Handicapped Program was to reserve one day a month for parent involvement in the classroom. Under this plan, parents were able to attend school with their child for a half-day. Materials and activities were provided for parents to do with their child, as well as a number of group activities in which parents could observe and participate. Although this program component was felt to be a valuable aspect in conjunction with home training, it was not received well by parents. Initial parent response was quite good and many parents elected to attend school with their child. However, after several months, parent response fell considerably and few, if any parents attended school. This component of the program also proved to be a significant amount of work for classroom teachers. Although, only several parents attended any one session, teachers spent a large amount of time instructing parents and familiarizing them with routines. This program aspect has since been abandoned, although, parents are allowed to visit classrooms to observe with advance notification and permission.

Home Involvement

Home training is an important part of the Kenosha Unified School District's E.C.H. Program as it is in any such program. Parent/child interactions and developmental training are critical in the remediation of developmental delays. In Kenosha, one-half day per week was set aside for home training. Students were dismissed from school following the A.M. session and home visits were made during the afternoon. This procedure was followed for one year when a recommendation for one-full day every two weeks for home visits was made. This schedule was felt to provide greater involvement than its half-day counterpart. It also did not significantly reduce any one group of children's classroom time. Previously, students attending the P.M. half-day program, lost one day a week of classroom programming.

The full day twice a month home visit schedule was followed for the second year. It did solve the before mentioned problems, however, it was felt that some parents needed support on a weekly basis, rather than twice a month. In its third year, the E.C.H. Program has returned to a half-day, once a week home visit schedule. Following its experimentation, this model was felt to best serve the needs of those involved. All drawbacks have not been eliminated however, an effective home training program is provided.

Parent Meetings

One evening a month is generally set aside for a parent in-service program. A number of presentations and a variety of topics have

been discussed in the past. Outside speakers including University faculty members, doctors and other specialists have been secured to address many developmental issues. Educational Publishers and Material Distributers have displayed, and explained many useful developmental aids. Other in-services have included: Home-made materials workshops, classroom open house, and local community agencies and support.

Behavior Management Programs

A number of behavioral management programs have been offered to the parents of the E.C.H. Program. The techniques employed have been those of the Systematic Training for Effective Parenting Program (S.T.E.P.). These in-service programs have been made available to parents during both school hours and in the evening to accommodate their schedules.

Speech Therapy

A speech clinician is assigned full time to the Early Childhood Program. This clinician, whose role is one of resource personnel has the opportunity to work in the classrooms performing general language stimulation in a group setting. This provides the clinician with the opportunity to coordinate activities, goals and procedures with the classroom teacher. The speech/language clinician also schedules children for individual therapy depending on their personal needs and physical limitations. The speech/language clinician is allowed one-half day per week to accompany the classroom teachers on home visits to assure parental training with regard to language stimulation.

Physical and Occupational Therapies

P.T. and O.T. services are provided for E.C.H. children with medical prescriptions and determined needs in either or both areas. Children are seen individually to meet objectives and therapists consult with teachers to provide classroom objectives and assure necessary modifications are made to meet the individual's needs.

Social Work/Psychological Services

Social Work and Psychological services are available as needed. In addition to diagnostic services, consultation with teachers and parents are available when necessary. Both the School Social Worker and the School Psychologist attend weekly staffing with other E.C.H. personnel.

Diagnostic Speech Clinician

The Diagnostic speech/language clinician is assigned to all of the Early Age evaluations. In conjunction with the psychologist, the speech clinician does an evaluation. The diagnostic clinician in conjunction with the speech clinician servicing the Early Age program determine the goals and objectives for children entering the program.

X. TEST MATERIALS AND ASSESSMENT INSTRUMENTS FOR USE IN EARLY AGE EVALUATIONS AND SCREENINGS

Kaufman Development Scale

The Kaufman is designed for developmental skill assessment of children from birth through fifteen years of age. Six individual scales contain tasks arranged in order of normal developmental accomplishment. An average Development Age is derived by averaging a child's performance on all six scales. Scales include: Gross Motor, Fine Motor, Receptive Modality, Expressive Modality, Personal Behavior Modality and Interpersonal Behavior Modality.

Developmental Profile

The Developmental Profile is an inventory of skills which has been designed to assess a child's development from birth to pre-adolescence. It consists of 217 items arranged into five scales on the basis of age levels. The age levels proceed thereafter by year intervals. The inventory provides a reliable screening of each of five areas: Physical Age, Self-Help Age, Social Age, Academic Age, and Communication Age. Administration time is approximately 20 - 40 minutes.

Denver Developmental Screening Test

This test was designed and standardized to meet the need of having a simple, useful tool to aid in the discovery of children with developmental problems. The test is designed for use with children between the ages of 1 month and 6 years. The test provides an indication of a child's skill development in the following areas: Personal/Social, Fine-Motor-Adaptive, Language and Gross Motor.

Minnesota Child Development Inventory

This inventory provides a systematic means of obtaining and summarizing parents' observations of their child without the expenditure of professional time. The MCDI is a standardized instrument for using a parent's observations to measure the development of the child. It is to be used with children from one to six years of age. The inventory consists of 320 statements which provide a concise picture of a child's development in a profile of eight developmental scales: General Development, Gross Motor, Fine Motor, Expressive Language, Comprehension-Conceptual, Situation-Comprehension, Self-Help and Personal/Social.

Multidimensional Description of Child Personality (PIC)

This instrument provides comprehensive and clinically relevant personality descriptions of individuals from three through sixteen years of age. The PIC consists of 600 questions which can be answered True or False regarding the respondent's opinion of a child's behavior, attitude and family relationships. Sixteen

scales provide information on how parents view their child. The scales include: Achievement, Intellectual Screening, Development, Somatic Concern, Depression, Family Relationships, Delinquency, Withdrawal, Anxiety, Psychosis, Hyperactivity, and Social Skills.

Burk's Behavior Rating Scales - Preschool and Kindergarten

This instrument was developed for use with children three years of age through six. It is designed to identify particular behavior problems and patterns of problems shown by children. An outside rater (teacher or parent) performs a quantitative judgment by determining the degree to which each of 105 behaviors is seen in the child. A total of eighteen categories of behavior are represented; i.e., withdrawal, anxiety, coordination, attention, impulse control, aggressiveness, resistance, etc.

Comprehensive Identification Process (CIP)

The CIP is a screening instrument designed for evaluating children between the ages of 2-1/2 and 5-1/2. Forms are available for recording observed behavior for use in social and affective behavior sections of screening. Specific tasks are established for fine motor, gross motor and cognitive/verbal skills assessment. Forms are also provided for social/medical information, as well as speech and language assessment. General guidelines are established for various ages to determine whether a more comprehensive evaluation is warranted following this screening.

D.I.A.L. Screening

The DIAL is a screening Instrument for use with children ages 2 years, 6 months to 5 years, 5 months. Individual tests are divided into four developmental areas: Gross Motor, Fine Motor, Concepts and Communication. Norms are established (cutoff points) for all age levels. The screening is administered in sections at various stations and takes approximately 30 minutes to complete.

Additional Developmental Checklists

Portage Checklist
Learning Accomplishment Profile
Carolina Developmental Checklist

Stanford-Binet Intelligence Scale

This instrument is designed for use with children and adolescents ages 2 - 18. Tests are grouped in terms of age levels, with a variety of skills measured at each level. Six tests and an alternative test are presented at each level. A mental age and IQ score are obtained. The child is given all tests within a basal (all tests passed at one age level) and a ceiling age (all tests failed at one age level).

Pictorial Test of Intelligence

This test may be used with children ages three to eight. It enables the child to respond in a multiple-choice fashion. Simple instructions are given and the subject responds by pointing to one of four pictures on a test card. Items on six subtests are arranged in order of difficulty: Form Discrimination, Information and Comprehension, Similarities, Size and Number, Immediate Recall, Picture Vocabulary.

Slosson Intelligence Test

This test is designed as an individual screening for both children and adults - ages 3 to 27. Items used in this short screening are similar to those on the Stanford-Binet and provide a mental age and intellectual quotient. Since it is a screening instrument, scores must be interpreted with some caution; however, as a screening instrument, some value exists.

Columbia Mental Maturity Scale

This is an individually administered test yielding an estimate of general reasoning ability of children aged 3 years 6 months through 9 years 11 months. The 92 pictorial and figural classification items are arranged in a series of eight overlapping scales or levels. The child is given the level appropriate for his chronological age. Each item consists of a series of from three to five drawings printed on a 6 by 19 inch card. The child is asked to look at all the pictures on the card and select (point out) the one which is different or unrelated to the others. This test provides a means to assess children with limited language or hearing impairments, and takes approximately 20 minutes to administer.

Hiskey-Nebraska Test of Learning Aptitude

This test was designed for use with both hearing and hearing impaired (deaf) children. It has been standardized for children ranging in age from two years six months to seventeen years five months. A variety of functions are measured in the eight subtests, which can be administered with oral directions or by demonstration (non-verbal). Age equivalencies obtained for each test and a total mental age and IQ can be derived.

Wide Range Achievement Test (WRAT)

The WRAT is a screening instrument which assesses word recognition (reading), spelling and arithmetic for ages 5 through 64. Scores provided include: grade equivalents, percentiles and standard scores.

Peabody Individual Achievement Test (PIAT)

This test is designed for children from kindergarten age to twelve years. Scores are provided for mathematics, reading (word recognition), reading comprehension, spelling, general information and total score. Motor responses are minimized by presenting the child with a stimulus and requiring a pointing response to select the correct answer from a multiple-choice format.

McCarthy Scales of Children's Abilities

This test is designed for use with children from 2-1/2 to 8-1/2 years old. The MSCA provides a scale index for the following areas: Verbal, Perceptual-Performance, Quantitative, Memory and Motor. A General Cognitive Index score can be derived and a position for evaluation of laterality is also provided. The measurements obtained serve as a valuable tool for examining individual differences in psychological processes.

Detroit Tests of Learning Aptitude

The Detroit is designed for use with children and adolescents 3 to 19 years of age. It is comprised of 19 subtests, each a scale in itself, and from these a variety of batteries may be selected for specific cases. These include the blind, hearing impaired, speech handicapped and orthopedically handicapped. Scores on individual subtests, which measure a variety of process functions, provide age equivalencies.

Developmental Test of Visual-Motor Integration (VMI)

This is a test consisting of a series of 24 geometric forms to be copied with pencil and paper. The forms are arranged in order of increasing difficulty. The test can be administered to children in the age range of two to fifteen years, but is designed primarily for the preschool and early primary grades.

Motor-Free Visual Perception Test

This is a test of visual-perception which avoids motor involvement and which is practical for screening, diagnostic and research purposes. The test is designed for use with children ages 4 through 9. A stimulus is presented and the child is required to point to the correct response from a series. The following visual perceptual functions are considered: spatial relationships, visual discrimination, figure-ground, visual closure, and visual-memory.

Goldman-Fristoe Test of Articulation

This test is designed to:

1. Examine all of the necessary phonemes.

2. Obtain an adequate and accurate sample of the subject's speech production under several conditions, ranging from imitative to conversational speech.

3. Be presented in a form that would be easy to administer, eliminating loose cards or objects as stimulus material.

4. Be presented in a kit which would contain all materials needed for testing articulation and recording results in a convenient form.

5. Be colorful and interesting.

6. Be conducive to the minimizing of distractions and to the focusing of the subject's attention on stimulus material.

7. Provide a form for recording responses which is easy to use and facilitates a comparative evaluation of the subject's pattern of errors under various test conditions.

The test makes use of three basic assessment procedures: (1) Sounds-in-Words, (2) Sounds-in-Sentences, and (3) the Stimulability Subtest. These procedures provide an efficient means of assessing spontaneous and imitative speech, and of examining all necessary phonemes.

Preschool Language Scale

The purpose of the section on Auditory Comprehension is to determine whether the child can receive auditory information, and can indicate this reception by a meaningful, non-verbal response. It provides a measuring instrument to register recognition and comprehension of noun and non-noun words, the stages of concrete and abstract thought, concept acquisition, and the ability to understand grammatical features of the language.

The Verbal Ability section of this scale will help determine whether a child can verbalize adequately, as measured by his/her responses to a series of graded tasks. It provides an instrument for measuring such aspects as vocabulary (word availability), verbalized memory span, stages of concrete and abstract thought, concept acquisition, articulation and ability to use grammatical features of the language.

Brigance Inventory of Early Development

This inventory was designed to be used in programs for infants and children below the developmental level of seven years. This inventory functions in the following ways:

1. As an assessment instrument.

2. As an instructional guide with objectives stated in functional and measurable terms.

3. As a record-keeping tracking system which is on-going and specific.

4. As a tool for developing and communicating an individualized education program.

5. As a resource for training parents and professionals in child growth and development.

The Inventory includes 98 skill sequences, from birth through developmental age of six years, for the following areas: Psychomotor, Self-Help, Speech and Language, General Knowledge and Comprehension, and Early Academic Skills.

Test for Auditory Comprehension of Language - Carrow

This test serves two primary functions. The first function is to measure the auditory comprehension of language structure and, on the basis of the child's performance, permits assignment of the child to a developmental level of comprehension. The second function is diagnostic. Performance on specific items and groups of items allow the examiner to determine the areas of linguistic difficulty. The child may have difficulty in understanding prepositions or pronouns, etc. This information provides a basis for educational planning and intervention.

The test instrument permits the assessment of oral language comprehension without requiring language expression from the child. The Test consists of 101 plates of line drawings. The pictures represent referential categories and contrasts that can be signaled by form classes and function words, morphological constructions, grammatical categories, and syntactic structure.